Filing at a Glance

Company:	Fidelity Life Association, A Legal Reserve Life Insurance Company
Product Name:	W6006A
State:	Arkansas
TOI:	L04G Group Life - Term
Sub-TOI:	L04G.103 Renewable - Single Life - Fixed/Indeterminate Premium
Filing Type:	Form
Date Submitted:	11/15/2012
SERFF Tr Num:	FDLR-128766815
SERFF Status:	Closed-Approved-Closed
State Tr Num:	
State Status:	Approved-Closed
Co Tr Num:	
Implementation Date Requested:	
Author(s):	Barbara Mooney
Reviewer(s):	Linda Bird (primary)
Disposition Date:	11/28/2012
Disposition Status:	Approved-Closed
Implementation Date:	

State Filing Description:

State: *Arkansas* **Filing Company:** *Fidelity Life Association, A Legal Reserve Life Insurance Company*

TOI/Sub-TOI: *L04G Group Life - Term/L04G.103 Renewable - Single Life - Fixed/Indeterminate Premium*

Product Name: *W6006A*

Project Name/Number: */*

General Information

Project Name:
Project Number:
Requested Filing Mode:
Explanation for Combination/Other:
Submission Type: New Submission
Group Market Type: Employer, Association, Other
Overall Rate Impact:

Deemer Date:
Submitted By: Barbara Mooney

Status of Filing in Domicile: Pending
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Group
Group Market Size: Small and Large
Explanation for Other Group Market Type: Union
Filing Status Changed: 11/28/2012
State Status Changed: 11/28/2012
Created By: Barbara Mooney
Corresponding Filing Tracking Number:

Filing Description:
Please review the cover letter

Company and Contact

Filing Contact Information

Ciaran Brady, Vice President - Operations
1211 W 22nd St, Suite 209
Oak Brook, IL 60523

Ciaran.Brady@FLA-Life.com
630-522-0392 [Phone]
630-522-0397 [FAX]

Filing Company Information

Fidelity Life Association, A Legal Reserve Life Insurance Company
1211 W 22nd St.
Suite 209
Oak Brook, IL 60523
(630) 522-0392 ext. [Phone]

CoCode: 63290
Group Code: 3413
Group Name:
FEIN Number: 36-1068685

State of Domicile: Illinois
Company Type: Life
State ID Number:

Filing Fees

Fee Required? Yes
Fee Amount: $50.00
Retaliatory? Yes
Fee Explanation: 1 form at $50
Per Company: No

Company	Amount	Date Processed	Transaction #
Fidelity Life Association, A Legal Reserve Life Insurance Company	$50.00	11/15/2012	64945628

SERFF Tracking #:	*FDLR-128766815*	***State Tracking #:***		***Company Tracking #:***	

State:	*Arkansas*	***Filing Company:***	*Fidelity Life Association, A Legal Reserve Life Insurance Company*
TOI/Sub-TOI:	*L04G Group Life - Term/L04G.103 Renewable - Single Life - Fixed/Indeterminate Premium*		
Product Name:	*W6006A*		
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	11/28/2012	11/28/2012

SERFF Tracking #:	*FDLR-128766815*	***State Tracking #:***		***Company Tracking #:***	

State:	*Arkansas*	***Filing Company:***	*Fidelity Life Association, A Legal Reserve Life Insurance Company*
TOI/Sub-TOI:	*L04G Group Life - Term/L04G.103 Renewable - Single Life - Fixed/Indeterminate Premium*		
Product Name:	*W6006A*		
Project Name/Number:	*/*		

Disposition

Disposition Date: 11/28/2012
Implementation Date:
Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		No
Supporting Document	Application		No
Supporting Document	Filing Authorization		No
Supporting Document	Statment of Variability		No
Supporting Document	Cover Letter		No
Form	Enrollment Form		No

SERFF Tracking #:	*FDLR-128766815*	***State Tracking #:***		***Company Tracking #:***	

State:	*Arkansas*	***Filing Company:***	*Fidelity Life Association, A Legal Reserve Life Insurance Company*
TOI/Sub-TOI:	*L04G Group Life - Term/L04G.103 Renewable - Single Life - Fixed/Indeterminate Premium*		
Product Name:	*W6006A*		
Project Name/Number:	*/*		

Form Schedule

Lead Form Number:								
Item No.	**Schedule Item Status**	**Form Name**	**Form Number**	**Form Type**	**Form Action**	**Action Specific Data**	**Readability Score**	**Attachments**
1		Enrollment Form	W6006A (10/12)	AEF	Initial			W6006A Enrollment Form.pdf

Form Type Legend:

ADV	Advertising	**AEF**	Application/Enrollment Form
CER	Certificate	**CERA**	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	**FND**	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	**NOC**	Notice of Coverage
OTH	Other	**OUT**	Outline of Coverage
PJK	Policy Jacket	**POL**	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	**SCH**	Schedule Pages

☐ New Contract
☐ Contract Change For #_____
☐ Reinstatement For #_____

Group Enrollment Form
Fidelity Life Association ("the Company")
Administrative Office: P.O. Box 506, Keene, N.H. 03431-0506

FIDELITYLIFE
Established 1896

I. [Employee/Payor Information]

Group Name_____ Location/Dept. _____

Name _____ Date of Hire _____Home Phone _____

Legal Address _____Email_____

Street City State Zip

Annual Salary _____Social Security # _____Employee ID _____

[Is the employee actively at work performing the regular duties of the job in the usual manner and the usual place of employment?] ☐ Yes ☐No

II. Proposed Insured Information

	Name	Gender	Birth Date	Age	Tobacco or Nicotine Products in Last 12 Months?
1. [Employee/Payor]:	_____	☐ M ☐F	_____	____	☐ Yes ☐No
2. Spouse:	_____	☐ M ☐F	_____	____	☐ Yes ☐No
3. Child 1:	_____	☐ M ☐F	_____	____	☐ Yes ☐No
4. Child 2:	_____	☐ M ☐F	_____	____	☐ Yes ☐No

III. Coverage Information **Planned Premium Mode: ☐Weekly ☐Bi- Weekly ☐Monthly ☐Other_____**

Base Plan: [Lifetime Benefit Term (LBT)]
[Employee/Payor] Face _____ Premium $_____
Is the Proposed Insured a U.S. Citizen or a permanent resident?
☐ Yes ☐No

Level Term Optional Benefit:
1. [Employee/Payor]: Face _____ Premium $_____
2. Spouse: Face _____ Premium $_____
3. Child 1: Face _____ Premium $_____
4. Child 2: Face _____ Premium $_____

Optional Benefits
[Employee/Payor:
☐ Waiver Premium $_____
☐ Dependent Child Benefit: ____Units Premium $_____
☐ Accidental Death Benefit Premium $_____
☐ LTC Premium $_____
☐ LTC/TI Combo Premium $_____
☐ EOB Premium $_____
☐ Guaranteed Insurance Option
☐ Other _____ Premium $_____
Total Planned Premium $_____]

Base Plan: [Lifetime Benefit Term (LBT)]
[Spouse] Face _____ Premium $_____
Is the Proposed Insured a U.S. Citizen or a permanent resident?
☐ Yes ☐No

Level Term Optional Benefit:
1. [Employee/Payor]: Face _____ Premium $_____
2. Spouse: Face _____ Premium $_____
3. Child 1: Face _____ Premium $_____
4. Child 2: Face _____ Premium $_____

[Spouse:
☐ Payor Waiver Premium $_____
☐ Dependent Child Benefit: ____Units Premium $_____
☐ Accidental Death Benefit Premium $_____
☐ LTC Premium $_____
☐ LTC/TI Combo Premium $_____
☐ EOB Premium $_____
☐ Guaranteed Insurance Option
☐ Other _____ Premium $_____
Total Planned Premium $_____]

IV. Beneficiary
The [Employee/Payor] will be the Beneficiary of any coverage issued on a Spouse or Child, unless otherwise stated in this section. The Spouse will be the Beneficiary of any coverage issued on the [Employee/Payor], unless otherwise stated in this section.
Insured: _____ Beneficiary: _____ Relationship: _____
Insured: _____ Beneficiary: _____ Relationship: _____

V. Certificate Holder
The [Employee/Payor] will be the Certificate Holder unless another is subsequently designated.

VI. Conditional Issue Questions: Please answer all required questions for any Person proposed for Coverage. If any question is answered "Yes" for any proposed insured, please answer all of the Simplified Eligibility questions on Page 2 for that Person.

Proposed Insured Person:	Employee Yes	Employee No	Spouse Yes	Spouse No	Child 1 Yes	Child 1 No	Child 2 Yes	Child 2 No
a. Has the [Employee/Payor] missed more than 5 days of active work due to an illness or injury in the past [3] months?	☐	☐	N/A		N/A		N/A	
b. Has any Proposed Insured been treated in a medical facility, hospitalized or disabled in the past [6] months? Hospitalized means in-patient or outpatient, whether or not confined.	☐	☐	☐	☐	☐	☐	☐	☐
c. Has any Proposed Insured, within the last 10 years, been diagnosed as having or been treated by a physician for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or tested positive for the Human Immunodeficiency Virus (HIV)?	☐	☐	☐	☐	☐	☐	☐	☐
d. Has any [Person/Spouse or Child] proposed for coverage been seen or treated by a licensed physician or other medical practitioner within the past [6] months?	☐	☐	☐	☐	☐	☐	☐	☐

VII. Other Coverage: Does any Person proposed for coverage have any life insurance in force or is any application for life insurance or reinstatement now pending? ☐ No ☐ Yes If Yes, complete the following:

Insured	Name of Company	Face Amount	Month/Year Issued	To be Replaced?
				☐ Yes ☐ No
				☐ Yes ☐ No

VIII. Simplified Issue Questions:

1. [Employee/Payor]: Height: ___Ft. ___In. Weight_____lbs.
2. Spouse: Height: ___Ft. ___In. Weight_____lbs.
3. Child 1: Height: ___Ft. ___In. Weight_____lbs.
4. Child 2: Height: ___Ft. ___In. Weight_____lbs.

Within the past 5 years, has any Person proposed for insurance been admitted or advised to be admitted to a hospital or received medical advice or treatment for:	Proposed Insured Person: Employee Yes	Employee No	Spouse Yes	Spouse No	Child 1 Yes	Child 1 No	Child 2 Yes	Child 2 No
a. any chest pain, heart disease, stroke or paralysis, lung or respiratory disease, blood disease or high blood pressure? If yes, provide most recent blood pressure reading and date: _____;	☐	☐	☐	☐	☐	☐	☐	☐
b. any cancer, tumor, disorder of the kidney, liver disease or hepatitis;	☐	☐	☐	☐	☐	☐	☐	☐
c. any mental or psychiatric disorder, stomach or intestinal disorder or reproductive organ disorder;	☐	☐	☐	☐	☐	☐	☐	☐
d. received or been advised to have, counseling or treatment for the use of alcohol, drugs, illegal drugs, or used any illegal drug or controlled substance;	☐	☐	☐	☐	☐	☐	☐	☐
e. taken any prescription medication in the past 6 months (If "Yes", state name of medication, reason for taking, frequency and dosage.);	☐	☐	☐	☐	☐	☐	☐	☐
f. had or been advised to have an electrocardiogram, x-ray, blood study, urinalysis, or any other diagnostic study, operation or treatment.	☐	☐	☐	☐	☐	☐	☐	☐
g. Other than stated above, within the past 5 years, had any other illness, operation or treatment?	☐	☐	☐	☐	☐	☐	☐	☐

Details: Provide full details of "yes" answers on Page 1 and 2. Include the diagnoses, date, duration, and names and address of all attending physicians and medical facilities.

Proposed Insured Person	Question #	Describe Injury, Illness, Disorder, Symptoms and Medication (include Dosage and frequency)	Date Diagnosed	Length of Treatment	Current Health Status	Name & Address of Doctor or Hospital

If more space is needed to provide details, attach a signed and dated additional sheet of paper.

Declaration, Agreement and Authorization To Release Information: I declare that each answer given to the questions contained in this enrollment form is complete and true to the best of my knowledge and belief. I understand and agree that the company will rely on these answers, and the answers and statements I may give in any other form taken as part of this enrollment form. I also understand that the Company reserves the right to accept or deny this enrollment form after taking into account whatever information may be available to it, including availability as to coverage by its reinsurers. All statements and answers on this enrollment form are full, complete and true to the best knowledge and belief of each person who has signed below.

The insurance being applied for will be effective as of the [enrollment form date, provided the person(s) to be insured is (are) found acceptable for such insurance as applied for].

I/We authorize any physician, medical practitioner, hospital, clinic, pharmacy, pharmacy benefit manager or other medical or medically related facility, insurance or reinsurance company, MIB, Inc. or employer to give to Fidelity Life Association any information they might have regarding the diagnosis, treatment, prescription and prognosis of any physical or mental condition as applicable. To facilitate the rapid transmissions of such information, I authorize all said sources, to give such records or knowledge to any agency employed by the Company to collect and transmit such information. I agree that this authorization shall remain in effect for two years (24 months) from the date that it is signed and that a copy of it shall be as valid as the original. I understand that the information obtained with this authorization shall be used to evaluate my request for insurance or to evaluate a claim during the time that this authorization is valid. I also understand that I, or someone I authorize to act on my behalf, may obtain a copy of this authorization.

All or part of such information may be disclosed to a physician of my choosing, my insurance agent, MIB, Inc., to other persons or organizations performing business or legal services in connection with this enrollment form, including reinsuring companies as may be required by law.

The Certificate Holder/Insured and the agent certify that no illustration conforming to the coverage applied for was provided, but that an illustration conforming to the coverage issued will be provided upon delivery.

Fraud Warning: Any person who knowingly presents a false or fraudulent claim for payment of a loss or knowingly makes a false statement in an enrollment form for insurance may be guilty of a criminal offense under state law.

Agent: To the best of your knowledge, will the coverage applied for replace any life or annuity coverage now in force on the life of any proposed Insured? (If Yes, complete appropriate State replacement forms) ..... ☐ Yes ☐ No

SIGNED AT: *(State)* *DATE:* SIGNATURE OF LICENSED AGENT:

SIGNATURE OF Employee/Payor: PRINTED NAME OF AGENT:

SIGNATURE OF SPOUSE OR CHILD: (if required) STATE LICENSE NUMBER: (if required by law)

SERFF Tracking #:	*FDLR-128766815*	***State Tracking #:***	***Company Tracking #:***

State:	*Arkansas*	***Filing Company:***	*Fidelity Life Association, A Legal Reserve Life Insurance Company*
TOI/Sub-TOI:	*L04G Group Life - Term/L04G.103 Renewable - Single Life - Fixed/Indeterminate Premium*		
Product Name:	*W6006A*		
Project Name/Number:	*/*		

Supporting Document Schedules

		Item Status:	**Status Date:**
Satisfied - Item:	Filing Authorization		
Comments:			
Attachment(s):			
Filing Auth 042012.pdf			

		Item Status:	**Status Date:**
Satisfied - Item:	Statment of Variability		
Comments:			
Attachment(s):			
W6006A Stmt of Variability.pdf			

		Item Status:	**Status Date:**
Satisfied - Item:	Cover Letter		
Comments:			
Attachment(s):			
Letter.pdf			

FIDELITYLIFE
Established 1896

Fidelity Life Association
8700 W. Bryn Mawr Ave., Ste 900S
Chicago, IL 60631
Tel 630.522.0392
Fax 866.375.8175

April 10, 2012

Company NAIC Number: 63290
Company FEIN Number: 95-1060502

Re: Group Life Insurance Policy, Certificate and Benefit Forms
Letter of Authorization

To: All State Insurance Departments

The Fidelity Life Association, A Legal Reserve Life Insurance Company of 8700 W. Bryn Mawr Ave, Ste. 900S, Chicago, Illinois hereby authorizes Vision Financial Corporation to represent us in the submission of the captioned forms and to negotiate with insurance departments for their approval.

Sincerely,

Ciaran Brady
Vice President of Operations

STATEMENT OF VARIABILITY

Form Number – W6006A
Description – Enrollment Form

Page Variable is Reflected On	Variable Language	Variable Text
1	Section 1	This section will reflect the information necessary to identify the group and the employee or member.
1	Are you actively at work performing the regular duties of your job in the usual manner and at the usual place of employment?	The question as stated will be asked of Employees of Employer Groups. When applicable, the question will be modified for Association Members to read: Are you an active member of the Association.
1	Section II	This section will reflect the name, gender, date of birth, age and smoking classification for each proposed covered insured person.
1	Section III	This section will reflect the coverage amounts and optional benefits for each proposed covered insured person.
1	Section IV	Reflects any unique beneficiary designation.
1	Section VI	Reflects the conditional issue underwriting questions for the proposed covered insured person.
1	Section VI – Question a	Period of time can be changed for certain enrollments (3,6,9,12 Months)
1	Section VI – Question b	Period of time can be changed for certain enrollments (3,6,9,12 Months)
1	Section VI – Question d	Period of time can be changed for certain enrollments (3,6,9,12 Months)
1	Section VII	Reflects the information regarding existing coverage or replacement activity for each proposed covered insured person.
1,2	Home Office Address	Will only change if the physical address of the Home Office Changes
2	Section VIII	Reflects the simplified issue underwriting questions for the proposed covered insured person.
2	The insurance being applied for will be effective as of the enrollment form date, provided the person(s) to be insured is (are) found acceptable for such insurance as applied for.	This statement will be changed for special enrollment situations where the enrollment may occur during a period in which deductions can not occur until several months later. Example: school systems where the enrollment may take place in June prior to the school closing for the summer and the deductions will be help until September when school starts up again. In this case the wording would read: The insurance being applied for will be effective as of the Coverage Date on the Certificate Schedule Page and not the date the enrollment form is signed.

November 15, 2012

Life Policy Analyst
Life and Health Division
Arkansas Insurance Department
1200 West 3rd St.
Little Rock, AR 72201

RE: Fidelity Life Association
NAIC No.: 63290
FEIN Number: 36-1068685
Group Enrollment Form – Form W6006A (10/12)

Dear Sir or Madam:

We are submitting the Group Enrollment Form identified above for your review and approval. This is a new form and will not replace any form previously approved by your Department.

This form will be used with the Lifetime Benefit Term contract previously approved by your Department or with any additional products that may be approved in the future.

This form does not contain any unusual or possibly controversial items, or provisions that deviate from normal company or industry standards.

Thank you for your assistance with this filing. If you have any questions, please call me at 1-800-635-4467, ext. 209.

Sincerely,

Crystle Harmon
Compliance Coordinator
Vision Financial Corporation
Telephone: 800-635-4467, ext. 209
Fax: 603-357-0250
Email: charmon@visfin.com

Enc.